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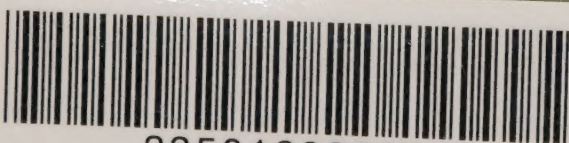
The
Manchester Joint Hospitals
Advisory Board.



THIRD
Annual Report
1937-1938.



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PREFACE.

INCEPTION OF THE MANCHESTER JOINT HOSPITALS ADVISORY BOARD.

Prior to 1930 there existed two main agencies offering hospital service to the community : the Voluntary Hospital and the Poor Law Hospital.

As a consequence of the provisions contained in the Local Government Act, 1929 (since repealed and re-enacted as Section 182 of the Public Health Act, 1936), the hospitals previously administered by the Boards of Guardians as Poor Law Hospitals were transferred to County and County Borough Councils, giving them, at the same time, the power to remove these establishments from their Poor Law association and to administer them under non-Poor Law legislation.

Since April, 1930 (the date of the operation of this Act), the hospital services of the various Councils have developed rapidly. There has thus appeared a new and powerful agency of hospital activity, for as hospitals under Public Health administration it has been necessary to effect great changes in staffing and equipment of such hospitals in order to fit them for their changed position in an endeavour to bring them up to, or even beyond, the standard of the Voluntary Hospital.

The hospitals thus transferred and administered under Public Health Acts are open not only to the poor but to all the inhabitants of the area.

In addition to this sweeping change Section 13 of this Act placed a statutory obligation upon Local Authorities to consult with representatives of the Voluntary Hospitals with regard to the provision of hospital accommodation generally, which suggested that hospital services should before long cease to have the sharp division as between voluntary and rate-aided establishments, and that in the future all hospitals should operate as one common provision for the benefit of the populace at large.

Hitherto, the County and County Borough Councils (including their predecessors in general hospital administration—the Boards of Guardians) and the Voluntary Hospitals had developed their various establishments as individual units without any regard to the overlapping of services or the need for co-operation, although all were animated with the one purpose, *i.e.*, to provide the best treatment of the sick at the lowest cost.

Section 13 of the Local Government Act, 1929, provided "that the council of every county and county borough shall, when making provision for hospital accommodation in discharge of the functions transferred to them under this Act, consult such committee or other body as they consider to represent both the governing bodies and the medical and surgical staffs of the voluntary hospitals providing services in or for the benefit of the county or county borough as to the accommodation to be provided and as to the purposes for which it is to be used."

By this it was suggested that progressive local authorities would, through such consultation, explore the hospital needs of their areas and envisage and plan complete hospital provision for the communities they represent, such services to continue the hospital services for the poor and create or supplement where necessary those for the rest of the community.

These needs cannot be satisfactorily met by merely delimiting spheres of independent and possibly competitive services, but only by the most intimate co-operation, adjusted to the altered conditions which must now prevail, between the Municipal and Voluntary Hospitals in any area.

Prior and subsequent to the passing of the 1929 Act, conferences took place from time to time between the Corporation and certain of the Voluntary Hospitals, but it was not until August, 1934, that the Public Health Committee of the Manchester City Council specifically appointed a Special Sub-Committee for the purpose of the consultation required by the Act.

The Committee, appreciating the complexity of the problem of co-ordinating the various "bodies" responsible for the administration of the hospitals in the City, decided not to restrict the terms of reference of this Special Sub-Committee, but rather to extend its activities in order to include consideration of the correlation of the work of the Municipal Hospitals and the Voluntary Hospitals. This action was foreshadowed in the Circulars accompanying the 1929 Act, which implied the establishment of the fullest co-operation between the various hospitals in any one district.

Meanwhile the Manchester Voluntary Hospitals Council, which was representative of the whole of the Voluntary Hospitals in the City, had also appointed a Statutory Committee for the purpose of the consultation with local authorities contemplated by Section 13 of the 1929 Act.

The first conference of the two "Section 13" committees, was held on the 26th March, 1935, when Dr. R. Veitch Clark the Medical Officer of Health of Manchester, placed before the meeting a proposal for the formation of a body, permanent in its constitution but acting in an advisory capacity, which would not only effectively replace the technical and legal consultation provided for by the Sub-Committee already appointed, but would ensure a measure of co-operation and co-ordination far greater than that required by Section 13 of the Act. It was suggested that such a body should be representative of the City Council and the Voluntary Hospitals Council and when consulted could, as a single governing body entrusted with the policy of hospital provision, both as regards quantity and type, whilst preserving the independence of the particular hospital concerned, advise any of the constituent hospital authorities as to the proper co-ordination of hospital services or on other matters or projects which required impartial decisions in the best interests of the hospitals in the city viewed as a whole. Co-operation there must be, not only between the Voluntary Hospitals and the local authorities, but between the Voluntary Hospitals themselves. Whilst the Municipal Hospitals have had the advantage of some form of central administration, inasmuch as the whole of the work of the various hospitals has been administered by one Committee, the Voluntary Hospitals, in some instances, have grown up in an atmosphere of parochialism, without contact or co-operation with neighbouring institutions of the same kind.

The proposal for the formation of such a Joint Board was favourably received by the representatives present at the conference and it was agreed that they would consult their respective Committees thereon.

When submitted to the Public Health Committee and the Voluntary Hospitals Council, the proposal was considered in the light that there was no legal obligation on the City Council to do more than merely consult with the representatives of the Voluntary Hospitals, but Section 13 of the Local Government Act, 1929, was accepted as being introduced into the Act in anticipation that such consultation must of necessity lead to co-operation. At the same time, whilst there would be no binding authority and no legal contract or agreement would result from the decisions of the Joint Board, it was clearly understood that unless in general the "constituent bodies" confirm the acts of their representatives on the Joint Board and subsequently the hospitals themselves adopt such decisions, the proposed machinery would fail in its object.

An intimation having been received that the various Committees received this proposal favourably, these decisions were reported to a further conference held on the 8th August, 1935, and as a result thereof the proposed constitution of such a Joint Hospitals Advisory Board was considered. It was the opinion of the conference that the Joint Board should be as representative as possible and that the University of Manchester should also be associated with and represented thereon as the Medical Teaching School of the City. An invitation was thereupon extended to the Council of the University to collaborate in this important work, such invitation being accepted with an assurance that the Council of the University desired to give all the assistance it could to the proposed Joint Board. Accordingly the Public Health Committee of the City Council and the Voluntary Hospitals Statutory Committee were recommended to approve of the constitution of a Joint Hospitals Advisory Board consisting of representatives of the Public Health Committee, the Voluntary Hospitals Council and Statutory Committee, and the University of Manchester.

These recommendations were approved by the City Council and the Voluntary Hospitals Council and Statutory Committee and on the 28th October, 1935, the first meeting of the Joint Hospitals Advisory Board was held.

R. H. ADCOCK,

R. L. NEWELL

Joint Honorary Secretaries.

THE MANCHESTER JOINT HOSPITALS ADVISORY BOARD.

List of Members, etc., 1937-38.

Chairman—SIR CHRISTOPHER T. NEEDHAM, B.A., D.L.

Vice-Chairman—COUNCILLOR R. G. EDWARDS.

Representing the City Council of Manchester :—

Councillor S. MEADOWCROFT (Chairman, Public Health Committee).

Alderman R. S. HARPER (Deputy-Chairman, Public Health Committee).

Alderman JACKSON, M.A.

Alderman M. L. KINGSMILL JONES, O.B.E.

Councillor W. CHADWICK, B.A., M.B., CH.B.

Councillor R. G. EDWARDS.

Councillor LARRAD.

Councillor SARAH LASKI.

Councillor ONIONS.

Councillor F. E. TYLECOTE, M.D., F.R.C.P.

The Medical Officer of Health.

Representing the Voluntary Hospitals Council :—

Mr. W. COBBETT, C.B.E.

Mr. F. HOLT DIGGLE, F.R.C.S.

Mr. J. W. A. EARLE, B.A.

Mr. A. E. GADDUM.

Mr. FRANCIS GRUNDY.

Mr. T. F. HEYWORTH.

Mr. H. PLATT, M.D., M.S., F.R.C.S.

Mr. JAMES SILLAVAN.

Representing the University of Manchester :—

Sir CHRISTOPHER T. NEEDHAM (Chairman, University Council).

The Vice-Chancellor (Professor JOHN S. B. STOPFORD, M.D., F.R.S.).

Professor A. RAMSBOTTOM, M.C., M.D., D.P.H., F.R.C.P.

Professor W. FLETCHER SHAW, M.D., M.R.C.P., F.C.O.G.

Professor JOHN MORLEY, M.B., CH.M., F.R.C.S.

Representing the Manchester Division, British Medical Association :—

Dr. R. G. MACGOWAN.

JOINT HONORARY SECRETARIES :—

R. H. ADCOCK,

Town Clerk,

Town Hall, Manchester, 2.

Telephone :—

Central 3377 (Ext. 206).

R. L. NEWELL, M.D., F.R.C.S.,

2, St. John Street,

Manchester, 3.

Telephone :—

Blackfriars 6505.

ASSISTANT SECRETARY :—

G. PLANT,

Town Clerk's Department,

Town Hall, Manchester, 2.

Telephone :—Central 3377 (Ext. 397).

THE MANCHESTER JOINT HOSPITALS ADVISORY BOARD.

List of Hospitals, etc., associated with the "Constituent Bodies."

No.	Name of Hospital or Kindred Institution	Number of Beds	
VOLUNTARY HOSPITAL COUNCIL.			
1	Manchester Royal Infirmary }	614	
	Manchester Barnes Convalescent Home }	136	
2	Royal Children's Hospital }	230	
	Children's Convalescent Home }	30	
3	Ancoats Hospital }	150	
	Ancoats Convalescent Home }	35	
4	St. Mary's Hospitals—		
	Whitworth Street }	178	
	High Street }	162	
5	Royal Eye Hospital	166	
6	Hospital for Incurables	131	
7	Jewish Hospital	103	
8	Manchester Northern Hospital	113	
9	Manchester Ear Hospital	24	
10	Hospital for Babies	80	
11	Hospital for Skin Diseases	54	
12	Christie Hospital and Holt Radium Institute ..	115	
		2,321	
PUBLIC HEALTH COMMITTEE.			
13	In Manchester {	Crumpsall Hospital	1,400
14		Withington Hospital	1,175
15		Booth Hall Hospital	760
16		Rose Hill Convalescent Home	100
17		Monsall Hospital	600
18		Baguley Sanatorium	333
		4,368	
UNIVERSITY OF MANCHESTER.			
19	Dental Hospital of Manchester	—	
TOTAL ..		6,689	

THE MANCHESTER JOINT HOSPITALS ADVISORY BOARD.

Constitutions and Functions.

Title.

1. The Board shall be known as "The Manchester Joint Hospitals Advisory Board" and is hereinafter referred to as the "Joint Board."

Constitution.

2. The Joint Board shall be representative of the Council of the City of Manchester (representing the Municipal Hospitals), the Hospitals Council and Statutory Committee (representing the Voluntary Hospitals), and the University of Manchester, which bodies are hereinafter referred to as the "constituent bodies," and in pursuance of resolutions of such constituent bodies, the Joint Board shall be constituted by the appointment of members as follows :—

Council of the City
of Manchester .. Ten members of the
Public Health Com-
mittee and the Medical
Officer of Health.

Hospitals Council and
Statutory Com-
mittee Eight members.

University of Man-
chester Five members.

Functions.

3. The Joint Board shall act solely in an advisory capacity and shall be empowered and required to advise each and every Hospital Authority controlled by, or associated with, the constituent bodies, such Hospital Authorities accepting in principle that the Joint Board shall be taken into consultation when major issues are involved in any proposed action.

Matters which now or hereafter may come under the consideration of the Joint Board are :—

(a) all or any of the matters referred to in Section 13 of the Local Government Act, 1929 ;

(b) any matters associated with the development of hospital work, including the provision of new hospital accommodation ;

- (c) extensions of, or additions to, existing hospital accommodation ;
- (d) the principles underlying the medical and surgical staffing of the hospitals concerned;
- (e) Medical Education and research ; and
- (f) all or any matters such as have relation to the work of the Voluntary and Municipal Hospitals controlled by the constituent bodies.

4. That a representative of any hospital affected shall be invited to attend, without voting powers, any meeting or meetings of the Joint Board or any Sub-Committee thereof during the consideration of and prior to arriving at any decision on any proposal affecting a particular hospital.

*Duration of
Office of
Members.*

5. The members of the Joint Board shall hold office for periods of three years, commencing on the 1st November of each year, and shall be eligible for re-election at the end of such period, provided that in the event of a member ceasing to be a member of the constituent body represented by him, he shall also cease to be a member of the Joint Board and the vacancy shall be filled as hereinafter specified.

*Re-election
of Members,
or Filling
Casual
Vacancies.*

6. The constituent bodies shall, by resolution, fill vacancies in their representation on the Joint Board (whether occasioned by the expiry of periods of office or from any other cause) either by re-election of the retiring member or members, or by the nomination of some other person in the place of the retiring member. Such resolution shall be adopted not less than twenty-eight days from the occurrence of the vacancy.

*Sub-
Committees.*

7. The Joint Board may from time to time appoint out of its own members such Sub-Committees consisting of such numbers of persons as it thinks fit, for any purpose which, in the opinion of the Joint Board, can best or most conveniently be dealt with by a Sub-Committee, and the Chairman and Vice-Chairman of the Joint Board shall be *ex-officio* members of all such Sub-Committees.

*Power
to Co-opt.*

8. The Joint Board may appoint to its own membership and/or to the membership of any Sub-Committee, or may allow any Sub-Committee to co-opt, without voting power, any persons

possessing a special knowledge which, in the opinion of the Joint Board or of the Sub-Committee, would be of material assistance to the Board or to the Sub-Committee.

Chairman and Vice-Chairman. 9. The Joint Board shall in November of each year appoint a Chairman and a Vice-Chairman, and the Chairman or, in his absence, the Vice-Chairman, shall preside at all meetings of the Joint Board. In the absence from any meeting of both the Chairman and the Vice-Chairman, a Chairman shall be elected to preside at such meeting.

The Chairman may be elected from among the members of the Joint Board without exception, but in the event of the Chairman being a member of the City Council's representation on the Joint Board, then the Vice-Chairman shall be elected from the Voluntary Hospitals' representation, and *vice-versa*. In the event of the Chairman being a member of the representation of the University, the Vice-Chairman shall be a member either of the City Council's representation or of the Voluntary Hospitals' representation.

Meetings. 10. The meetings of the Joint Board shall be held at the call of the Chairman, provided that meetings be called no less frequently than one in every three months. Special meetings of the Joint Board shall be called by the Chairman when circumstances warrant, and extraordinary meetings may also be called on the requisition of not less than one-quarter of the members of the Joint Board.

Place of Meeting. 11. The meetings of the Joint Board shall be held in the Town Hall, Manchester.

Quorum. 12. A quorum shall consist of nine members of the Joint Board possessing voting powers and a quorum for Sub-Committees shall consist of any three members thereof possessing voting powers.

Notice of Meetings. 13. Not less than seven clear days' notice of meeting of the Joint Board shall be given to members, and the matters to be discussed at any meeting shall be stated upon the notice convening the meeting.

Officers.

14. The Joint Board shall have power to make such arrangements as are necessary to carry out the secretarial and clerical work of the Joint Board, including power to appoint such officers and servants as it may from time to time deem necessary, any one or all of whom may be honorary or paid as the Joint Board shall determine.

*Issue of
Proceedings.*

15. The proceedings of the Joint Board at each and every meeting shall be issued in *extenso* to the constituent bodies and to each member of the Joint Board but shall not be issued to individual hospitals.

*Standing
Orders.*

16. The Joint Board may from time to time make Standing Orders for the regulation of their proceedings and business and may at any time vary or revoke the same provided that due notice of the intention to make such amendment shall have been given.

THE MANCHESTER JOINT HOSPITALS

ADVISORY BOARD.

Third Annual Report, 1937-38.

The Board has pleasure in submitting its Third Annual Report.

Although considerable interruption was caused by the international crisis, the year under review has been an important one. Agreement has been reached with regard to the proposals for the solution of two major problems, *i.e.* :

- (1) Co-ordination of the various hospital services relative to the treatment of fractures ;
- (2) Co-ordination of thoracic surgery services.

TREATMENT OF FRACTURES.

The question of unification of orthopaedic services within the City has been briefly referred to in the previous Annual Reports of the Board. The object has been to devise a scheme to restore persons who have suffered from injuries involving fracture to maximum functional activity. This includes adequate " follow up " measures so that the injured persons may resume their normal activities in the shortest time possible, having regard to all the requirements of the necessary treatment. To achieve this objective it is of primary importance that all fracture work at each of the hospitals should be concentrated on one consultant surgeon and one resident surgeon acting under the direction of the consultant ; it was felt also that the fullest co-operation between the various hospitals could best be achieved by the appointment of an honorary adviser upon orthopaedic services.

The report prepared by the medical members of the Unification of Orthopaedic Services Committee was approved in principle by the Joint Board as a basis for discussion with the hospitals affected thereby.

Representatives of the hospitals affected attended a later meeting of the Joint Board and it is pleasing to record that all the constituent bodies concerned have intimated their willingness to join in the carrying out of the proposals set forth in the following report.

REPORT OF THE SPECIAL SURGICAL SUB-COMMITTEE
re
TREATMENT OF FRACTURES.

Part I.

History.

1. The Ministry of Health on the 18th February, 1935, forwarded to all County Councils and County Borough Councils, Circular No. 1462 enclosing a copy of a report issued by the British Medical Association on the Treatment of Fractures, with the suggestion that in any consideration of the question of organising a "fracture unit" the Council would no doubt consult with the authorities of the voluntary hospitals serving their area.

2. This circular and report were referred by the Public Health Committee and the City Council to the Joint Board for consideration.

3. The report of the British Medical Association contained a summary of the dimensions of the problem, the period of disability, and the existing organised fracture services. In conclusion, the report pointed out that the essentials of an organised fracture unit could be summed up under four headings :—

- (a) Segregation of cases ;
- (b) Continuity of treatment ;
- (c) After-care ;
- (d) Unity of control ;

and a summary of these is set out hereunder :—

4. (a) *Segregation*.—Segregation of the cases into one department, where they can be uniformly handled by a specially trained and experienced staff would seem to be a first essential of any organisation. It is not essential, and possibly not desirable, that fracture cases should be

segregated into one special hospital, but it does appear to be vitally important that every hospital which proposes to deal with fractures should segregate its cases and establish one, and only one, organisation. There is probably no hospital in the country which deals with such a large number of cases as to demand the maintenance of more than one organisation. Duplication leads to confusion and to loss of efficiency, and only by establishing one invariable routine of organisation may it be certain that no case can escape from the routine and fail to receive that daily personal supervision of the expert which is so essential. Only by segregation can the staff become sufficiently highly trained, skilled, and experienced in the technical application of modern methods and in the handling of special appliances.

5. It appears to the Committee that the teaching of students and post-graduates would be facilitated and not hindered by such segregation, since the teacher would have at his disposal many instances of the same class of fracture. It would be possible to demonstrate various methods carried out with perfect technique, instead of being limited to the few chance cases which might come to any particular ward. Attendance at such a fracture unit and service as a dresser should be an essential part of undergraduate medical education.

6. (b) *Continuity of Treatment*.—The aim of fracture organisation must be not merely the exact reduction of fractures, but the return of patients to maximum functional activity. Co-ordination of the successive stages of treatment, which should be closely related as integral parts of a unified whole, is essential. The fracture unit staff must be responsible for the treatment of the patient from beginning to end, from the primary reduction to complete restoration of function. In-patients and out-patients should be treated by the same staff. The same continuous case record should follow the patient from the casualty department to the wards and to the out-patient department. Physiotherapy and all remedial measures will be the responsibility of the fracture unit staff.

7. (c) *After-care*.—The Committee point out that excellent primary treatment is of little avail in many fractures unless it is followed up by a phase of active exercise directed to complete restoration of function; it is this latter phase which is so commonly absent. Moreover, it is suggested that no fracture organisation can be complete

without adequate "follow-up" measures. Domiciliary visitations by the right kind of person under the direction of the Almoner is of considerable value in achieving the proper relationship, and, as a result, in securing the regular attendance and willing co-operation of the patient.

8. (d) *Unity of Control*.—It is pointed out that segregation, continuity and after-care achieve their greatest value only if there is unity of control. All the stages of treatment of each case need not only expert supervision, but supervision by one expert. In most large hospitals there is one surgeon who is more interested and more expert in the treatment of fractures than any other; to him should be delegated the work.

9. In addition, the report suggested the following as a model fracture unit :—

Personnel.—Surgeon in Charge. Such visiting surgeons as are interested in the clinic. Chief Assistant (Registrar, Assistant Surgeon) should possess a special qualification in surgery. Senior Casualty Officer and Resident House Surgeon. Specially trained nursing staff and staff qualified in physical treatment. Almoner.

Accommodation.—Examination room, X-ray room adjoining, plaster and splint room, and Almoner's room in which records are preserved.

Attendance.—The Fracture Clinic (in-patients and out-patients) attended by the Chief Assistant and his staff is held daily. Weekly clinics or bi-weekly clinics are held, attended by the Surgeon-in-charge, the Chief Assistant, and his staff;

at the same time indicating the method of dealing with ambulatory fractures and in-patient fractures, and recommending the establishment of one rehabilitation centre in each industrial area.

10. Where the fracture service provided is a combination of municipal and voluntary agencies, the report pointed out that it was of great importance to ensure by the closest co-ordination and joint staffing that the patients are under the close and continuous care of the one fracture team.

Part II.

Inter-Departmental Committee.

11. The members of the Executive Committee of the Joint Board had an opportunity of informally discussing this problem with members of the Inter-Departmental Committee appointed by the Home Office, the Ministry of Health, and the Scottish Office on the Rehabilitation of Persons Injured by Accidents upon a visit of the Inter-Departmental Committee to inspect the Fracture Clinic at the Manchester Royal Infirmary on the 16th July, 1936.

12. In connection with this visit to Fracture Clinics, the Chairman of the Inter-Departmental Committee had previously addressed a Questionnaire to all County and County Borough Councils, and voluntary hospitals, as to—

(a) the average annual number and local distribution of injuries by accident treated in the hospitals of the country—and in particular the number and distribution of fracture cases so treated; and

(b) the nature of the existing arrangements at the hospitals for the treatment of *fracture* cases;

and for the information of the members of the Committee to be appointed by the Joint Board a copy of the replies to this Questionnaire was obtained.

Inter-Departmental Committee's Interim Report.

13. On a later date the Ministry of Health issued Circular 1632 together with the Interim Report of the Inter-Departmental Committee on the Rehabilitation of Persons Injured by Accidents, and in the Circular the Minister expressed the hope that if the Council proposed to establish a clinic for the treatment of fractures, either under the Public Health or the Poor Law Acts, reference will be made to the detailed scheme advised by the Inter-Departmental Committee.

14. This Interim Report states that the general principles of organisation and treatment set out in the report of the British Medical Association were accepted by the Government Departments concerned, and that the object in view was the provision throughout the country of Fracture Services which would place within the reach of every injured person the benefits of the improved methods of treatment with the threefold result of mitigating suffering, reducing the period of disablement, and the loss of working and earning power, and securing wherever possible complete restoration of working capacity.

15. The report then sets out the results of the survey of the present position throughout the country so far as treatment of fractures is concerned, but, in view of the comprehensive details of the local conditions which have been made available to the Special Sub-Committee of the Joint Board, no useful purpose would be served by a reiteration of the survey of the country.

16. As a result of the attention which has been called to the problem of Treatment of Fractures, the report states that a widespread movement for the establishment of fracture clinics has begun and is likely to make rapid headway, but it appeared to the Committee to be most important that this movement should be so directed as to secure that the clinics are established on right lines, and are so distributed as to supply the needs of all to prevent overlapping and to provide the maximum of efficient service.

Scheme of Organisation.

17. The Inter-Departmental Committee state that the object aimed at is to bring all fracture cases under a unified control, and to ensure that the treatment continues under the same supervision until the process of rehabilitation is complete ; and suggest that, on the personnel side, the Department should be placed as a general rule under the charge of one of the visiting surgeons ; and that one or more whole-time assistant surgical officers would be needed, according to the size of clinic and the number of cases treated. Adequate clerical assistance would be necessary for the keeping of the records of cases treated, and the maintenance of an adequate follow-up system of all cases ; and an X-ray technician must always be available at any time, day or night, so that there may be no delay in the X-ray examination, by which alone the treatment of fractures can be accurately controlled.

Staffing.

18. The Inter-Departmental Committee recommend one departure from ordinary practice in respect of the remuneration of the surgeon in charge. It is not the custom for the visiting staff of a voluntary hospital to receive any remuneration for their services, but, as the surgeon-in-charge of a fracture clinic organised on the lines proposed will undertake much more onerous duties than those usually falling to a visiting surgeon, and will probably be compelled to give up other remunerative work for the purpose, it is desirable that he should receive some honorarium for his services ; otherwise it may be difficult to secure the man best qualified for the work.

19. The report further states that the standard of work for a fracture clinic will depend primarily on the detailed supervision and the personal direction of the treatment of cases by the surgeon-in-charge. The surgeons assisting, whether holding the position of Registrars (or Chief Assistants) or House Surgeons, will not be permanent members of the staff, and it will devolve upon the surgeon-in-charge to train and supervise a succession of such men. This will involve frequent attendance and a considerable part of his time, and it will perhaps be accepted that a staff of four assistants, one of whom will be a chief assistant, would be the maximum staff that could at any one time be supervised and trained. Such a team would be sufficient, with the application of modern methods, to deal with between 3,000 and 3,500 cases a year, of which more than two-thirds in all probability would be out-patients only. On the assumption that the average duration of the in-patient treatment of a case would be two weeks, the accommodation required would be about 40 beds.

Part III.

Terms of Reference.

20. The Joint Board appointed the following members :—

Chairman of the Joint Board ;
Deputy Chairman of the Joint Board ;
Councillor Meadowcroft ;
The Medical Officer of Health ;
Mr. W. Cobbett ;
Mr. A. E. Gaddum ;
Mr. H. Platt ;
Professor John Morley ; and
Professor E. D. Telford

to consider the report of the British Medical Association relating to the Treatment of Fractures and the general question of the unification of orthopaedic services.

21. A meeting of this Committee was held on the 21st December, 1936, when Sir Christopher Needham was appointed Chairman of the Committee. After a general discussion of the problem upon information then available, the Committee considered that this was a matter which required specialised knowledge. Accordingly the following Sub-Committee was appointed

to consider and submit for the consideration of the Committee a scheme for the unification of orthopaedic services within the City :—

The Medical Officer of Health ;

Mr. Harry Platt ;

Professor John Morley ;

Professor E. D. Telford ; with

Mr. R. L. Newell as convenor ;

and authority was given for this Special Sub-Committee to appoint to its membership without voting power any person possessing special knowledge which, in the opinion of the Special Sub-Committee, would be of material assistance.

22. At the first meeting of this Special Sub-Committee, Professor E. D. Telford was appointed Chairman.

Scope of the Fracture Problem in Manchester.

23. According to the information submitted to the Special Sub-Committee, and an analysis prepared by Mr. Harry Platt, the number of cases treated in 1936 by the voluntary and municipal hospitals, were as follows :—

Voluntary Hospitals	4,925
Municipal Hospitals	1,030
	5,955

24. In 1935 the fracture material of the municipal hospitals consisted of :—

“ First-hand ” cases	535
Transfers from voluntary hospitals..	238, or
	30 per cent.
	of total.

No figures for 1936 were available, but if the proportion of transfers remained unaltered, the number of “ first-hand ” fractures for 1936 would be in the neighbourhood of 700. It would appear, therefore, that under ordinary circumstances the combined Manchester Hospitals will be called upon to deal with an average of 5,500 new fracture patients each year.

Relative Proportions of Fractures.

25. The relative proportions of ambulatory fractures (treated throughout as out-patients), and non-ambulatory fractures (treated in the early stages as in-patients), in 1936, were as follows :—

	Ambulatory	Non-ambulatory
Voluntary Hospitals ..	4,404	521
Municipal Hospitals ..	219	811

26. From a comparison of information obtained for the two years 1935 and 1936, it appears that there was a slight decline in the in-patient fracture admissions to the voluntary hospitals from 673 in 1935 to 521 in 1936, whereas there was a substantial rise in the in-patient fractures treated in the municipal hospital from 673 in 1935 to 811 in 1936, whilst in both hospital groups there was an increase in the number of out-patient fractures.

Types of Fractures Treated.

27. From information obtained from records at the Manchester Royal Infirmary and Ancoats Hospital, it appears that in the voluntary hospitals the proportion of upper limb to lower limb injuries remains constant, *i.e.*, upper limb fractures constitute two-thirds of the total. In the municipal hospitals, however, the figures for 1936 were :—

Upper limb	52 per cent.
Lower limb	48 „

Predominating Types.

Upper Limb.

28. The predominating types of the 2,605 fractures of the upper limb during 1936 were as follows :—

	per cent	
997 Colles fractures	37	} 83 per cent. of the total
566 fractures of the hand	21	
385 forearm fractures in children ..	14	
312 fractures of the clavicle	11	
2,260		

and in respect of these it is interesting to note that the disability resulting from the fracture and the type of “splinting” used in the treatment of the fracture did not prevent the patients from making repeated journeys in comparative comfort—on foot or by tram or bus—to the hospital of their choice.

Lower Limb.

29. The predominant type of the 1,677 lower limb fractures during 1936 consisted of :—

Foot (small bones) fractures.. ..	283—16	per cent.
Tibia and Fibula combined	240—14	„
Pott's (ankle joint) fractures.. ..	172—10	„
Femur (shaft) fractures	122— 7	„
Neck of femur fractures	102— 6	„

Period of Hospitalisation.

30. Of the fractures in these groups—

Neck of Femur and Shaft of Femur..	}	Required long period of hospital- isation.
Fractures of the leg bones		
“ Pott's ” fractures ..		Required short or moderate periods of hospitalisation.
“ Pott's ” fractures ..		The majority required a few days' in-patient treatment.
Foot fractures		The majority treated throughout as ambulatory patients.

Transfer of Patients between Voluntary and Municipal Hospitals.

31. From the figures available for 1935, it appears that of the 773 fractures treated in the three municipal hospitals, *i.e.*, Booth Hall, Crumpsall, and Withington, 238 were transfers from the voluntary hospitals. The reasons for the transfers were not available, but it may be assumed that—

(a) Lack of accommodation, and

(b) The social and economic circumstances of the patients are a sufficient explanation.

Circumstances in which Fractures are Sustained.

32. A survey of the 1935 and 1936 figures of the Manchester Royal Infirmary fracture service, based on accurate information which was available in 4,400 of the cases, shows that the comparative incidence of fractures in the three groups recently adopted by the Inter-Departmental Committee are as follows :—

Street (where a moving vehicle is concerned)	18	per cent.
Industrial	12	„
Domestic (including sport, etc.)	70	„

the proportion of children in the 1936 figures being 30 per cent.

Head Injuries.

33. The problem of head injuries is, to some extent, related to the problem of the organisation of fracture treatment ; but, whilst exact statistics are not available from all the hospitals, it appears that in 1936, in 7 hospitals, 159 fractures of the skull were treated. It is probable that an additional 200 head injuries diagnosed as concussion were dealt with during the same period, and this would suggest that the Manchester hospitals must provide for a yearly quota of 400 head injuries of varying severity, of which the majority will require in-patient treatment. This question is more intimately concerned with the future development of a co-ordinated **neurological service** between the Voluntary and Municipal Hospitals, consideration of which will no doubt be given by the Joint Board in due course.

Part IV.

Objects.

34. The Special Sub-Committee held three meetings, and, with all the information available, gave consideration to the type of scheme to be recommended to the Joint Board to provide prompt and efficient treatment for all fractures coming within the immediate sphere of influence of the Manchester hospitals, at the same time endeavouring to prevent overlapping and duplication of services.

Co-opted Members.

35. In order to assist the Special Sub-Committee, the following Orthopaedic Consultants were invited to attend and express their views :—Mr. R. Ollerenshaw, Mr. E. S. Brentnall, and Mr. H. O. Clarke ; and their services in this regard have been appreciated. It is regretted that the Honorary Surgeon of the Manchester Victoria Memorial Jewish Hospital could not attend.

36. It was considered by the Special Sub-Committee that the objects outlined in paragraph 34 of the report could be achieved by one of the following methods :—

- (a) Unification of the fracture service by the provision of one main fracture hospital with subsidiary units ; or
- (b) Establishment of co-ordination between fracture units.

Existing Fracture Units.

37. At the present time fracture patients are being treated at—

Manchester Royal Infirmary ;
Ancoats Hospital ;
Manchester Victoria Memorial Jewish Hospital ;
Crumpsall Hospital ;
Withington Hospital ;

utilising Booth Hall Hospital for some of the children ; but the Special Sub-Committee is satisfied that only in two hospitals, *i.e.*, Manchester Royal Infirmary and Ancoats Hospital, does the fracture organisation conform to the principles laid down in the reports of the British Medical Association and Inter-Departmental Committee.

Geographical Division.

38. From a résumé of the facts as now submitted, the present units can be divided as follows :—

Northern—Ancoats Hospital —Large O.P. fracture clinic.
—Small I.P. clinic.

—Crumpsall —Small O.P. clinic.
—Moderate sized I.P. clinic.

—Jewish —Moderate O.P. clinic.
—Very small I.P. clinic.

Central —Manchester Royal
Infirmary —Large O.P. and I.P. clinics.

Southern—Withington
Hospital —Small O.P. clinic.
—Large I.P. clinic.

39. The Special Sub-Committee have been faced with a difficulty, in so far as the accommodation for in-patient fractures at the Voluntary Hospitals is limited, and this fact alone means the recognition of some form of co-ordination (which to some extent exists at the present time), in order to secure transfer and interchange of cases between the Voluntary and Municipal Hospitals.

40. The principles which should govern co-ordination were set out in the Report of the British Medical Association, and are referred to in paragraphs 3 to 8 of this report. The Special Sub-Committee, in accepting these principles, now submit the following proposals respecting the present fracture service, in

an endeavour to secure co-ordination and unity of control through all the stages of treatment. These principles should govern the larger problem of the co-ordination of a number of fracture units serving the City, and be applied to those fracture units at present existing for their future co-ordination on the lines suggested.

41. Having regard to the distribution of population (in which recognition has been given to the rapid development which is at present proceeding in the northern and southern portions of the City), and of the convenience of the present "natural" distribution of units which had grown up undirected, as evidenced by the use made of such units, the Special Sub-Committee is satisfied that one hospital cannot supply the whole of the fracture needs of the City.

42. The geographical relationship of the proposed fracture clinics and their accessibility to ambulatory patients has been considered, and the Special Sub-Committee consider it desirable that one fracture centre should be officially recognised for each of the Northern, Central, and Southern portions of the City.

43. Although the fracture services at present existing comply to some extent with the opinions expressed in the Report of the British Medical Association, the Special Sub-Committee realise that further improvements in the services, with a view to co-ordination, could be made. Whilst the establishment of larger complete units on the lines of the recent Orthopaedic Unit of the Manchester Royal Infirmary is very desirable, such proposals would present formidable financial and administrative difficulties.

44. Under these circumstances, therefore, the Special Sub-Committee suggest the adoption of a gradual policy towards complete co-operation. During the period of this experimental arrangement, however, a common form of record sheet for "transfer" purposes should be utilised by all hospitals dealing with fractures. This is regarded as essential to any interchange of patients between hospitals.

45. Having regard to the work of the present "natural" distribution of fracture units and the formidable difficulties in obtaining the complete segregation of all fracture cases under one team, the Special Sub-Committee make the following recommendations.

Part V.

Recommendations.

Northern Division.

46. That Crumpsall Hospital should act as the main *in-patient fracture centre* for the Northern Division, and should work in intimate co-operation with Ancoats and the Jewish Hospitals by effecting a free interchange of patients.

47. The Special Sub-Committee is satisfied that Ancoats Hospital should continue to act as a primary fracture centre, both for a limited in-patient service and as the chief out-patient or ambulatory service in the Northern area. It is hoped in the future that the Jewish Hospital will see the desirability of adopting the principles laid down in the reports of the British Medical Association and Inter-Departmental Committee respecting segregation of fractures. With its limited in-patient accommodation, it should continue to provide a useful moderate-sized out-patient service.

48. This arrangement would permit of such cases as may be desirable being transferred back from Crumpsall Hospital, when they reach the ambulatory stage, for continuation of out-patient treatment at Ancoats and the Jewish Hospitals.

49. The ideal arrangement for the medical staffing of the Northern Division would be that the Surgeon-in-Charge of the fracture service at Ancoats Hospital would be also responsible for the similar service at Crumpsall Hospital. Whilst this cannot be established at present, the achievement of this ideal arrangement, as and when vacancies occur, should be borne in mind by the appointing authority or hospital. In the meantime, however, the closest co-operation should be effected with a view to creating a unified system in the Northern Division of the City.

Central Division.

50. The Special Sub-Committee is satisfied that the present fracture clinic of the Manchester Royal Infirmary can not only efficiently serve the Central Division of the City, but is large enough to fulfil its special responsibilities with regard to the undergraduate teaching, post-graduate training, and investigation and research. Although the in-patient service at the Manchester Royal Infirmary and its Convalescent Hospital is sufficient for a fracture service dealing with 2,500 cases per annum, the in-patient accommodation at times is liable to be overtaxed; thus the necessity for transfer and interchange of fracture patients to both Crumpsall and Withington Hospitals is essential.

Southern Division.

51. The Special Sub-Committee is satisfied that the fracture clinic at Withington Hospital should be encouraged to expand and develop its accommodation for in-patient fractures. The close geographical relationship of this hospital with the Manchester Royal Infirmary makes it unnecessary at present for Withington Hospital to develop a large out-patient and ambulatory service.

52. Due regard, however, must be paid to the rapidly increasing population in the southern portion of the City, especially Wythenshawe, and it is probable that experience may reveal the necessity to establish an out-patient and ambulatory service to meet the needs of this growing population.

Part VI.

Co-operation.

53. Whilst making these recommendations for partial centralisation, the Special Sub-Committee cannot stress too highly the necessity for the closest co-operation of all the units in the three divisions.

54. The problem of fractures, difficult as it is from the point of view of co-ordination, is part only of the much larger problem of the Unification of Orthopaedic Services as a whole. The Special Sub-Committee is satisfied that the fullest co-operation can best be achieved by the appointment of an Adviser upon Orthopaedic Services. The duty of the Adviser will be to report to the Joint Hospitals Advisory Board upon any matters which in his opinion will further this object.

Rehabilitation Centre.

55. As an outcome of the recommendations of this Special Sub-Committee, including the appointment of an Adviser upon Orthopaedic Services, the Joint Board will, in the future, be required to give consideration to the establishment of a rehabilitation centre in connection with the fracture services.

56. In conclusion, the members of the Special Sub-Committee would like to record their appreciation of the assistance rendered by Professor E. D. Telford in this matter, and express their regret that ill-health has necessitated his resignation from the Joint Board prior to the submission of this report.

CO-ORDINATED THORACIC SURGERY SERVICE.

The attention of the Joint Board was also directed to the question of the development of thoracic surgery in Manchester. It was pointed out that if thoracic surgery is to be done efficiently, it is of primary importance that it must be concentrated so that not only the operating team, but also the medical and nursing staff who will have the subsequent care of the patient may be experienced in this very specialised type of work. It was realised that this could only be achieved by means of ordered planning. It would be ideal if all patients—tuberculous and non-tuberculous—were treated in the same department at the same hospital.

One of the main questions to be considered, however, in any such plan was that of pulmonary tuberculosis, and the reasons are very obvious why it is not desirable to make a regular practice of treating cases of pulmonary tuberculosis in the wards of a general hospital. Moreover the routine treatment of these cases is one of the duties imposed upon the Local Health Authorities and is undertaken by the Public Health Service.

The opinion was expressed that a co-ordinated Thoracic Surgery Service should be divided to this extent—that the non-tuberculous patients should continue to be treated at the Royal Infirmary, and that the tuberculous ones should have their surgical treatment in Municipal Hospitals and Sanatoria.

The problem can, therefore, be summarised as the attainment of four, in some ways incompatible, ends :—

- (a) Concentration of the work ;
- (b) Separation of tuberculous from non-tuberculous patients ;
- (c) Provision of adequate surgical facilities and personnel for the particular type of treatment to be used ; and
- (d) Continuity of treatment of tuberculous patients.

In the practical application of these considerations to the inception of the co-ordinated thoracic surgery service, it became apparent that some compromise would be necessary at first, as there exists a department of thoracic surgery at the Manchester Royal Infirmary, a sanatorium at Baguley within reasonable distance of the City, and tuberculosis wards at Withington Hospital where a modern operating theatre is provided.

As an outcome of these considerations, the practical suggestions submitted and approved were as follows :—

- (1) That all non-tuberculous cases requiring thoracic surgery should be concentrated at the Manchester Royal Infirmary.
- (2) That surgical treatment of cases of pulmonary tuberculosis which is normally part of routine sanatorium treatment should continue to be given as at present in the various sanatoria.
- (3) That those requiring the services of a surgeon but no elaborate arrangements and no prolonged surgical after-care should be concentrated at Baguley Sanatorium.
- (4) That surgical treatment of tuberculous cases which require all the resources of a full operating team, a modern operating theatre, and a specially experienced surgical nursing staff for after-care, should be concentrated in the tuberculosis wards at Withington Hospital.

The scheme as approved provides for the possibility of patients from outside Manchester being treated at Baguley or Withington. These could only be accepted in consideration of an undertaking being obtained from the local authority of the patient's area of residence to bear all the charges involved. The Public Health Committee have, however, resolved that, so far as the municipal hospitals are concerned, non-Manchester cases should only be taken after all Manchester needs (both for thoracic surgery and all other forms of treatment of pulmonary tuberculosis) have been satisfied.

To make this an effective unit service Mr. Graham Bryce, F.R.C.S., has been appointed as the Surgeon-in-Charge of both of the clinics thus established at the Manchester Royal Infirmary and Withington Hospital; the necessary steps will be taken to strengthen the consultant anaesthetist staff at Withington Hospital to cope with thoracic surgery sessions which are to be added, and arrangements are being made for a sufficient number of operating theatre nurses and ward nurses to be sent to the Brompton Hospital for a short period of training in thoracic surgery procedure and surgical after-care.

CENTRAL BRANCH OF THE MANCHESTER ROYAL INFIRMARY.

The Board of Management of the Manchester Royal Infirmary were gravely concerned with the proposal of H.M. Office of Works to erect a new Employment Exchange building on the south side of the Central Branch of the Manchester Royal Infirmary in Roby Street. The great height and close proximity of the building would so severely have affected the Central Branch as to jeopardise its continued use as a hospital in the centre of the City. The Joint Board and the Public Health Committee associated themselves strongly with the Board of Management in their efforts to obtain an alteration of the plans in regard to the proposal. It is satisfactory to record that the negotiations with H.M. Office of Works resulted in a settlement which will ensure continuity of the Central Branch of the Manchester Royal Infirmary as an integral part of the City's hospital service.

DIRECTORS OR ADVISERS OF CLINICAL SERVICES.

In the First Annual Report of the Joint Board a reference was made to the recommendations of the Committee appointed by the Joint Board to consider the proposals of the Public Health Committee relative to the re-organisation of the consultant services in the municipal hospitals.

One of the many recommendations made and adopted by the Public Health Committee was the desirability of appointing gentlemen possessing experience of the wider problems of hospital policy, teaching, and research, as directors in the main branches of medicine, in the municipal hospitals, with a view to ensuring the proper development of these services.

These appointments were made for an experimental period and were confined to medicine, surgery, and gynaecology, with a view to the co-ordination of these services.

During this experimental period, the Joint Board have from time to time expressed the opinion that the directorships should not be confined to municipal hospitals, but that any such appointment should enable the holders to envisage the clinical services of all the hospitals in the City—both municipal and voluntary.

This experimental period has now ended, and having regard to the opinion of the Joint Board, the Public Health Committee approved the recommendation of the Medical Officer of Health that the directorships as limited to the municipal hospitals be not renewed. This recommendation was addressed to the Joint

Board expressing the view that if such honorary directorships be continued, they should be attached to the Joint Board and cover all the constituent hospitals in their functions; so that the true perspective of the services involving all the hospitals in the City be available to the Joint Board as the body entrusted with such work.

The Joint Board is now giving consideration to this expression of opinion—the duties which should be attached to these positions, and the method to be adopted in connection with the appointment thereof. A tentative decision has already been arrived at whereby these positions in the future will be designated as honorary advisers.

HEARING AID CLINICS.

A circular letter from the National Institute for the Deaf which has been addressed to the voluntary hospitals of the City, suggesting the establishment of a hearing-aid clinic in connection with the hospital has been referred to the Joint Board for consideration.

The circular letter stated that the proposal was made in consequence of the experience of the Institute in dealing with large numbers of deaf and deafened persons who have consulted the Institute on the need and choice of aids to hearing.

A brief survey of the position in Manchester was submitted to the Joint Board. From this it appeared that this problem would require consideration and consultation with the constituent bodies affected. The matter has, therefore, been referred to the Executive Committee of the Board for consideration and report.

In the meantime the various hospital authorities are being requested to take no further action on the letter from the National Institute for the Deaf until such time as a decision thereon has been taken by the Joint Board.

RESIGNATIONS, ETC.

The Board accepted with great regret the resignation of Professor E. D. Telford, F.R.C.S., who has given invaluable help in every phase of the Board's work. It also regrets the resignation of Mr. F. E. Warbreck Howell, on his leaving the City, as Joint Honorary Secretary, but is happy to state that Mr. R. H. Adcock, Town Clerk of Manchester, has accepted the invitation to fill the vacancy.

In submitting this Annual Report, the Board wishes to record that it continues to receive the co-operation and support of its constituent bodies and that in its view the aims, as stated in the Constitution and Functions, are being gradually attained.

C. T. NEEDHAM,
Chairman.

R. G. EDWARDS,
Vice-Chairman.

